DIVISIONS III & IV

ARKANSAS COURT OF APPEALS
NOT DESIGNATED FOR PUBLICATION
KAREN R. BAKER, Judge

CA05-1213

OCTOBER 25, 2006

JERRY WILSON

APPELLANT

v.

JENNIFER CONSTRUCTION CO. and CINCINNATI INSURANCE CO.

APPELLEE

APPEAL FROM THE WORKERS' COMPENSATION COMMISSION
[E809076]

AFFIRMED

Appellant Jerry Wilson challenges the Workers' Compensation Commission's decision denying him benefits based on the Commission's holding that no objective findings continued to exist that would support an award of permanent impairment. Appellant argues that the decision is not supported by substantial evidence. We find no error and affirm.

This case has been the subject of previous hearings and appeals reviewing appellant's entitlement to additional medical treatment and temporary total disability. As for the issue relevant to this appeal, the parties stipulated that on July 7, 1998, appellant sustained a compensable injury to his lumbar spine and a deep vein thrombosis to his right leg when several roof trusses fell on appellant, striking his right hip and back. A hearing was held before an administrative law judge on August 4, 2003, on the issue of entitlement to permanent impairment rating benefits. Due to conflicting medical evidence, the ALJ entered an interim order on September 23, 2003, directing that an independent medical examination and evaluation

be conducted and explaining that he was ordering this evaluation because he found significant and conflicting medical evidence which were extremely difficult to reconcile in addition to his personal observation of a part of the appellant's anatomy. The physician who examined appellant pursuant to this order was Dr. Rosenzweig. After this independent evaluation was performed, the ALJ awarded impairment benefits for a rating of 5% to the body as a whole for the condition appellant's back and 25% to the right lower extremity for post traumatic deep veined thrombosis.

Contending that the appropriate impairment rating to appellant's body as a whole should be 33%, appellant filed an appeal of the ALJ's decision. In an opinion filed August 12, 2005, the Commission reversed entirely the prior ruling of the ALJ and found that appellant was not entitled to any benefits for permanent impairment. It is from this opinion that the appeal before us was filed.

When reviewing a decision of the Workers' Compensation Commission, we view the evidence and all reasonable inferences deducible therefrom in the light most favorable to the findings of the Commission and affirm that decision if it is supported by substantial evidence. *Clark v. Peabody Testing Serv.*, 265 Ark. 489, 579 S.W.2d 360 (1979); *Crossett Sch. Dist. v. Gourley*, 50 Ark. App. 1, 899 S.W.2d 482 (1995). Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Wright v. ABC Air, Inc.,* 44 Ark. App. 5, 864 S.W.2d 871 (1993). The issue is not whether we might have reached a different result or whether the evidence would have supported a contrary finding; even if a preponderance of the evidence might indicate a contrary result, if reasonable minds could reach

the Commission's conclusion, we must affirm its decision. *St. Vincent Infirmary Med. Ctr. v. Brown*, 53 Ark. App. 30, 917 S.W.2d 550 (1996).

The Commission is required to weigh the evidence impartially without giving the benefit of the doubt to any party. *Keller v. L.A. Darling Fixtures*, 40 Ark.App. 94, 845 S.W.2d 15 (1992). The Commission also has the duty of weighing the medical evidence as it does any other evidence. *Roberson v. Waste Management*, 58 Ark. App. 11, 944 S.W.2d 858 (1997). The Commission has the authority to accept or reject medical opinions, and its resolution of the medical evidence has the force and effect of a jury verdict. *Poulan Weed Eater v. Marshall,* 79 Ark. App. 129, 84 S.W.3d 878 (2002). When the Commission denies benefits upon finding that the claimant failed to meet his burden of proof, the substantial evidence standard of review requires that we affirm if the Commission's decision displays a substantial basis for the denial of relief. *Cooper v. Hiland Dairy*, 69 Ark. App. 200, 11 S.W.3d 5 (2000). In addition, the Commission cannot arbitrarily disregard any witness's testimony. *Freeman v. Con-Agra Frozen Foods*, 344 Ark. 296, 40 S.W.3d 760 (2001).

The record and argument in this case are replete with contradictory medical evidence regarding appellant's condition. However, it is the Commission's province, not ours, to weigh the evidence and reconcile any inconsistencies. Our role is limited to determining whether the Commission's decision displays a substantial basis for the denial of relief. Hiland Dairy, *supra*.

In reaching its decision, the Commission made the following observations regarding Dr. Rosenzweig's evaluation performed pursuant to the interim order:

> Dr. Rosenzweig in deposition conceded that the 5% impairment for the abdominal wall injury was related to prior hernia injury, the etiology of which was unknown.

Dr. Rosenzweig conceded that his rating for the back was "probably degenerative in nature."

Drs. Simpson, Engelhoven, Chakales, and Moore treated appellant but none addressed any permanent impairment for appellant's back..

Rosenzweig conceded that the chronic lymphedema and the DVT should be rated to he right lower extremity as a whole using the 4th ed. AMA guides to permanent impairment.

Dr. Rosenzweig was confused on how to issue ratings for DVT, noting that he testified that he had limited experience with DVT and it was not something he normally treated, and that he issued a rating based upon the swelling he observed. Dr. Rosenzweig also stated that appellant advised him that appellant was not capable of doing housework, but appellant's testimony in his deposition and at the hearing contradicted this statement; thus making the history relied upon by Dr. Rosenzweig unreliable.

Dr. Moore and Dr. May opined that the DVT had resolved.

Dr. May, who was a friend of appellant's brother and was clearly an advocate for appellant, used inappropriate standards and incorrect edition of the AMA guides.

Appellant had no testing on the right lower extremity since 1999 and no treatment since 2000.

Given our standard of review and the explanation by the Commission regarding its resolution of the conflicting medical evidence, we cannot say that the Commission erred in reaching its decision. Accordingly, we affirm.

Affirmed.

PITTMAN, C.J., GLADWIN, BIRD, and GLOVER, JJ., agree.

ROAF, J., dissents.

ANDREE LAYTON ROAF, Judge, dissenting. I would reverse and remand this case to the Commission for determination of an appropriate permanent-impairment rating for appellant Jerry Wilson. While I agree that the medical evidence bearing on the issue of Wilson's entitlement to permanent-impairment benefits is to some extent conflicting, the conflicts primarily involve the degree of impairment due to his back and vascular leg injuries, not any lack of impairment. All of the physicians charged with assigning a rating, except the company's

selection, Dr. Moore, did so. Indeed, none of the objective signs of Wilson's injury, including fibrous mass of tissue, spasms, tenderness, scoliosis, discoloration, and rigid muscles were even noted by Dr. Moore in his exam. This failure so concerned the ALJ when he observed some of these signs himself in the hearing that he ordered an independent evaluation.

With regard to Wilson's back injury, considering Wilson's medical history, it was improper for the Commission to base its denial of a permanent impairment rating for the back, in part, on the failure of some of Wilson's treating physicians to assign an impairment rating. Dr. Simpson did not even treat Wilson's back problems, and Drs. Engelhoven and Chakales were self-referred physicians whom Wilson had to pay for himself after appellee controverted his right to benefits. In addition, the fact remains that all of the medical opinions agreed that Wilson suffered from a lumbar spine injury.

Both Dr. May and Dr. Moore agreed that Wilson's back injury was attributable to his work-related accident. Dr. Moore diagnosed Wilson with musculoligamentous sprain/strain and lumbar contusion. Dr. May testified that this was the same diagnosis that he himself made and that a lumbar contusion is a deep bruise. While it is true that Dr. May used an incorrect edition of the AMA Guides, there was no evidence that he did not interpret the tables properly, and it does not explain away the fact that Dr. Rosenzweig, the doctor assigned by the ALJ to do an independent evaluation, issued impairment ratings using the proper Guides. Moreover, Dr. May explained why he assigned Wilson a three perecent rating for pain; and although it was improper for him to do so, it was a mistake of Arkansas law, not a mistake of medicine. In addition, Dr. May's recommendations were based on objective findings. Dr. May testified that he considered his physical examinations to be "very objective." Dr. May further testified that when he

examined Wilson some four years after his 1998 injury, he "felt a very, very thick ridge of subcutaneous fibrous tissue over his iliac crest" that was "tender to palpation" and that the objective findings of his examination were the "scoliosis, the fibrous mass, the rigid paraspinal muscles and the pigmentation changes." Dr. May opined that the findings were a direct result of the injury and that he gave his opinions with a reasonable degree of medical certainty. Swelling is an objective finding, and the swelling was detected by Dr. May and confirmed by Dr. Rosenzweig. In addition, the swelling, scarring, or discoloration was objectively verified by the ALJ.

In fact, the Commission gave great weight to Dr. Moore's recommendation for an impairment rating for Wilson's back; however, Dr. Moore is a neurosurgeon, while Drs. Chakales, May, and Rosenzweig are orthopedic surgeons. It stands to reason that Dr. Moore would not be as experienced in issuing impairment ratings for back injuries.

Finally, the Commission opined that Dr. Rosenzweig's rating was based upon degenerative changes and an unreliable history provided by Wilson. Dr. Rosenzweig testified that Wilson told him that he was in pain and was unable to perform household chores; Dr. Rosenzweig evaluated Wilson on November 18, 2003. The Commission points to the fact that Wilson testified at the August 4, 2003 hearing that he does the "cooking, cleaning, laundry, and dishes" because he lives with his brother who is disabled. Here, Wilson's medical records indicate that he has been consistent in his complaints from the time of the accident and that it was proper for Dr. Rosenzweig to rely to some extent on Wilson's statements.

In short, while the Commission is free to weigh the medical evidence, it cannot arbitrarily disregard medical evidence. *See Patchell v. Wal-Mart Stores*, 86 Ark. App. 230, 184

S.W.3d 31 (2004). The Commission's decision to deny Wilson an impairment rating for his back is not supported by substantial evidence.

With regard to Wilson's vascular injury, the Commission based its refusal to assign an impairment rating for the deep vein thrombosis (DVT), in part, on the fact that Dr. Rosenzweig admitted that he had limited experienced treating DVT, or other vascular injuries. While Dr. Rosenzweig may not be an expert, he did have some experience with these conditions; the other physicians did not indicate that they had any experience with vascular conditions at all.

Also, the Commission noted that Dr. Rosenzweig's rating was based on swelling, and that Dr. Rosenzweig indicated that the swelling could be variable at different times throughout the day, depending on the level of activity, or could be influenced by the wearing of support hose.

The Commission further noted that Dr. Rosenzweig was "confused on how to issue ratings" for DVT because he relied upon table 14, Lower Extremity Impairment Due to Peripheral Vascular Disease to the Body as a Whole, as opposed to table 69, Lower Extremity Impairment Due to Peripheral Vascular Disease. While Dr. Rosenzweig admitted that he used table 14 because he saw it first, and would have used table 69 if he had come across it first, the tables are exactly the same, and the Commission does not state that Dr. Rosenzweig came up with the wrong impairment ratings, only that he used the wrong table. Simply because the wrong table may have been used does not negate the fact that an impairment rating was and should have been made. The Commission has the authority to itself issue ratings using the Guide, commonly does so, and could have amended Dr. Rosenzweig's numbers if it felt that he used the wrong tables. In addition, Dr. Rosenzweig a neutral and trusted medical professional

whom the Commission often uses to make independent medical evaluations, stated during his deposition that he stood by his impairment ratings, but agreed that the rating for DVT should be to the right lower extremity.

In sum, the Commission did not have any concrete evidence on which it could base its denial of an impairment rating for Wilson's DVT. All of the medical evidence points to the fact that Wilson in fact suffered from DVT. The fact that he did not complain of pain is not significant because swelling was objectively observed; also, Dr. Moore's opinion that the DVT was "resolved" is not significant because Dr. Rosenzweig testified that there is really no consensus on the medical definition of "resolved" and Dr. Moore is a neurosurgeon who did not treat Wilson for his DVT.

The Commission ultimately questioned the "credibility" of Doctors May and Rosenzweig and the methods by which they arrived at the ratings they assigned, but totally relied upon Dr. Moore, who noted none of the objective signs of injury in the evaluation that was, of course, made at the request of the insurance carrier. This is mind-boggling, because Dr. Wilson's evaluation was so deficient in failing to observe or note the objective signs of Wilson's injuries still present some four years after several roof trusses fell on his hip and back that the ALJ felt the need to order a third independent evaluation. The Commission could very well have assigned a rating, excising the portions assigned for abdominal-wall injury and for pain which it found objectionable, or come up with its own rating. Instead, it relied on the one physician who noted none of Wilson's objective signs, and, not coincidentally, assigned no rating at all. Even with the substantial evidence standard of review. I am unable to affirm this case. We have often said that, while the substantial evidence standard of review serves to insulate the Commission

from judicial review, a total insulation would render our function in these cases meaningless. *See e.g. Boyd v. Dana Corp.* 62 Ark. App. 78, 966 S.W.2d 946 (1998). Accordingly, I would remand this case to the Commission to assign some degree of permanent-impairment rating consistent with the AMA Guides, with the Commission's oft-cited expertise, and with its clear duty to do so in this instance.